Mail completed copy to:

Department of Labor and Industry
PO Box 64221
St. Paul, MN 55164-0221
(651) 284-5030 or
1-800-342-5354 (DIAL-DLI)

R-2
Rehabilitation Plan

PRINT IN INK or TYPE
Enter dates in MM/DD/YYYY format.

Reset

R E 0 1

DO NOT USE THIS SPACE

Private or confidential data you supply on this form will be used to process your workers' compensation claim. The data will be used by department of labor and industry (department) staff who have authorized access to the data, and may be used for state investigations and statistics. You may refuse to supply the data, but if you refuse your claim may be delayed or denied, or the form may be returned to you. The data will be made part of the department's file for your claim and may be supplied to: anyone who has access to the file or the data by authorization or court order; the employer and insurer for your claim; the office of administrative hearings; the workers' compensation court of appeals; the departments of revenue and health; and the workers' compensation reinsurance association.

1. WID or SSN	2. DATE OF INJURY
3. EMPLOYEE NAME	
4. EMPLOYEE ADDRESS	
CITY STATE ZIP CODE	5. EMPLOYEE PHONE NUMBER / 6. DATE OF BIRTH

7. EMPLOYER NAME	8. EMPLOYER CONTACT PERSON	9. PHONE #
10. INSURER CLAIM NUMBER	15. QRC NAME	
11. INSURER/SELF-INSURER/TPA	16. QRC FIRM	
12. INSURER ADDRESS	17. ADDRESS	
CITY STATE ZIP CODE	CITY STATE ZIP CODE	
13. CLAIM REPRESENTATIVE / 14. PHONE NUMBER	18. QRC # / 19. QRC FIRM # / 20. QRC PHONE NUMBER	

21. Occupation at time of injury

22. Pre-injury AWW

23. Job at date of injury: ☐ Part time ☐ Full time

24. Employee's work status

- ☐ a. Off work from DOI to start of rehabilitation
- ☐ b. Some work between DOI and start of rehabilitation, not working at start of rehabilitation
- ☐ c. Working at start of rehabilitation

25. Highest grade completed (select one)

- ☐ a. No high school diploma or GED
- ☐ b. High school diploma or GED
- ☐ c. Some post secondary course work
- ☐ d. Post secondary vocational/technical program
- ☐ e. Bachelor's degree
- ☐ f. Master's, PhD or professional degree

26. Employee may require an interpreter: ☐ Yes ☐ No

27. Date of rehabilitation consultation (start date)

28. Vocation goal

☐ a. RTW same employer ☐ b. RTW different employer

Comments:

VOCATIONAL REHABILITATION PLAN

SERVICE CATEGORY and CODE (from VRI)	DESCRIPTION	SERVICE START DATE	SERVICE END DATE	ESTIMATED DAYS	ESTIMATED COST
			TOTALS		

Employee Comments:

STATEMENT OF EMPLOYER/INSURER RESPONSIBILITY: The employer/insurer understands its responsibility to pay for services reasonably required and to monitor the costs and timelines of the services. M.S. § 176.102, subd. 9 and Minn. Rules 5220.1900, subp. 1g.

STATEMENT OF QRC RESPONSIBILITY: I understand that I am responsible for the timely delivery of the above specified services pursuant to M.S. § 176.102 and Minn. Rules 5220.0100-.1900 and agree to conscientiously carry out my professional duties as a Qualified Rehabilitation Consultant in the interest of the employee's rehabilitation. Should the estimated cost of this plan be exceeded or if additional time is required for completion of the plan, I will notify the Department and the parties by submitting a Rehabilitation Plan Amendment (R-3) in accordance with M.S. § 176.102, subd. 8 and Minn. Rules 5220.0510.

STATEMENT OF EMPLOYEE RESPONSIBILITY: I understand that it is my responsibility to cooperate with all parties involved in my rehabilitation and I agree to make a good faith effort to participate in this plan. This includes attendance at scheduled activities and appointments, and adherence to reasonable medical advice.

TO THE PARTIES: If you disagree with the plan, you have 15 days from the receipt of the proposed plan to resolve the disagreement or object to the proposed plan. The objection must be filed with the Department on a Rehabilitation Request form.

Send a copy of this plan to the employee's treating health care provider if permitted by Minn. Rules 5220.1802, subp. 5 (Minn. Rules 5220.0410, subp. 7).

Attach a copy of your initial evaluation report (Minn. Rules 5220.1803, subp. 5).

☐ Employee has read and signed the form "Rights and Responsibilities of the Injured Worker"

☐ Employee has read and declined to sign the form "Rights and Responsibilities of the Injured Worker"

Employee Signature	Date
Claim Representative Signature	Date
QRC Signature	Date

This material can be made available in different forms, such as large print, Braille or on a tape. To request, call (651) 284-5030 or 1-800-342-5354 (DIAL-DLI)/Voice or TDD (651) 297-4198.

ANY PERSON WHO, WITH INTENT TO DEFRAUD, RECEIVES WORKERS' COMPENSATION BENEFITS TO WHICH THE PERSON IS NOT ENTITLED BY KNOWINGLY MISREPRESENTING, MISSTATING, OR FAILING TO DISCLOSE ANY MATERIAL FACT IS GUILTY OF THEFT AND SHALL BE SENTENCED PURSUANT TO SECTION 609.52, SUBDIVISION 3.